



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST NORTHWEST
3255 WEST PIONEER PARKWAY
ARLINGTON TX 76013

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-05-A536-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This is considered a 'trauma' admit and can be exempt from the per diem rates. Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. Medicare would have allowed this facility \$4950.06 for DRG 219. We are asking the allowable to be 140%-over-Medicare (\$6390.09). This would leave a supplement payment of \$2975.79 due at this time."

Amount in Dispute: \$4298.91

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "It is this carrier's position that a fair and reasonable reimbursement for the dates of service in dispute was reimbursed. This carrier reimbursed the requester this carrier's fair and reasonable per diem reimbursement for a trauma in-patient surgical stay at \$1,234 a day for 3 days. This carrier also reimbursed the requester fair and reasonable reimbursement for the implants at invoice rate plus 10%."

Response Submitted by: Deborah Bailey, Texas Mutual Insurance Co., 221 West 6th Street, Suite 300, Austin, TX 78749

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2004 through October 17, 2004	Inpatient Services	\$4298.91	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."
4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on July 20, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on July 27, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 217-The value of this procedure is included in the value of another procedure performed on this date.
 - 426-Reimbursed to fair and reasonable.
 - CAC-W4-No additional reimbursement allowed after review of appeal/reconsideration.
 - CAC-18-Duplicate claim/service.
 - 878-Duplicate appeal. Request medical dispute resolution through DWC for continued disagreement of original appeal decision.
 - 891-The insurance company is reducing or denying payment after reconsideration.
 - M-No MAR.
 - F-Fee guideline MAR reduction.

Findings

1. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 824.6. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
2. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
3. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
 - The requestor's position statement asserts that "This is considered a 'trauma' admit and can be exempt from the per diem rates. Knowing that TWCC is hoping to move to a %-over-Medicare allowance for hospital claims, we have reviewed the Medicare DRG allowance and decided your reimbursement does not meet our own determination of fair and reasonable. Medicare would have allowed this facility \$4950.06 for DRG 219. We are asking the allowable to be 140%-over-Medicare (\$6390.09). This would leave a supplement payment of \$2975.79 due at this time."
 - The requestor did not discuss or explain how it determined that 140% of the Medicare rate would yield a fair and reasonable reimbursement.
 - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
 - The requestor did not support that payment of the requested amount would satisfy the requirements of 28

Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

_____	_____	10/6/2011
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.